General

Guideline Title

Occupational therapy practice guidelines for early childhood: birth through 5 years.

Bibliographic Source(s)

Clark GF, Kingsley K. Occupational therapy practice guidelines for early childhood: birth through 5 years. Bethesda (MD): American Occupational Therapy Association, Inc. (AOTA); 2013. 154 p. [304 references]

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse: In addition to the evidence-based recommendations below, the guideline includes extensive information on the referral and evaluation process, including creation of the occupational profile and the development of an intervention plan.

Definitions for the strength of recommendations (A–D, I) and levels of evidence (I–V) are provided at the end of the "Major Recommendations" field.

Recommendations for Occupational Therapy Intervention for Early Childhood: Birth Through 5 Years

Interventions	Recommended	No Recommendation	Not Recommended
Social–Emotional			
Touch-based interventions	• Infant massage to improve sleep and relaxation, reduce crying, and reduce hormones affecting stress, but no change for cognitive and behavioral outcomes (A) • Massage before bed to improve attention, reduce restless and impulsive behavior, and decrease stereotypical behaviors in young children (B) • Kangaroo Care to promote social–emotional development, eye–hand coordination, and speech (B)		
	• Caregiver-facilitated play to reduce anxiety in children		

Interventions	Recommended	No Recommendation	Not Recommended
Relationship-based intervention	and parents and to increase developmentally competent play (B) • Use of responsive teaching methods by parents to increase attention, persistence, interest, cooperation, initiation, joint attention, affect, and social–emotional functioning (C)		
Interactional/play-based activities	• Discrete trial combined with either semistructured play sessions or pivotal response training to improve structured play (A) • Discrete trial combined with either semistructured play sessions or pivotal response training to improve symbolic play (I)		
Naturalistic interventions	• Mixed play groups (children with and without disabilities) to improve responsiveness to peers and improve total positive behavior for both groups (B) • Instruction of preschool pairs in using a computer to increase active waiting, turn-taking, and positive affect (C) • Visually scheduled and scripted instructor-guided play to improve dyad engagement (I)		
Instruction-based intervention	• Modeling, play-based activities, rehearsal of social behaviors, and prompting to improve social behaviors (A) • Direct teaching with video modeling and applied behavior analysis to improve social skills (A) • Pivotal response training and environmental arrangement to prolong social interaction (A) • Social Stories to reduce inappropriate behaviors and increase appropriate behaviors (I)		
Therapist-selected toys and objects	• Use of social toys to promote cooperative play and positive social outcomes (B) • Mixed-level play groups for children with disabilities and children paired with peers with better play skills to improve social outcomes (B)		
Feeding, Eating, and Swallowing			
Behavioral-based intervention	• Use of behavioral interventions to increase calorie intake (B) • Use of behavioral interventions to wean from tube feedings (C)		
Parent-directed educational-based interventions	• Use of individualized behavioral feeding intervention to increase physical growth of infants (B) • Parent education and parent-directed intervention reduces maternal stress (B) • Use of behavioral interventions to increase food acceptance during mealtimes (C) • Parent education and parent-directed intervention to improve mealtime behaviors and reduce problem behaviors (C)		
Physiological interventions	• Oral stimulation programs to increase nonnutritive sucking pressure and the quantity of milk ingested during oral feeding (A) • Oral stimulation programs, skin-to-skin contact, and sensory–motor–oral interventions to reduce the length of hospital stay (A) • Tactile and multisensory interventions to improve nipple		

Interventions	Recommended	No Recommendation	Not Recommended
	feeding (B) • Oral stimulation, early introduction of oral feeding, and Votja's techniques to improve transition from tube to oral feeding (I)		
Cognitive Interventions			
Neonatal intensive care unit (NICU)	• Use of Newborn Individualized Developmental Care and Assessment Program to improve infant cognitive development (I)		
NICU and home-based interventions	• A multisensory approach addressing auditory, tactile, visual, and vestibular input in the hospital and at home until 2 months' corrected age to improve mental and motor performance (B) • Use of a parent education program that includes information on behavior, interaction with infants, and activities to promote development (B) • An early intervention program for preterm infants to improve cognitive outcomes in infancy and preschool (B)		
Intervention to promote joint attention	• Intervention incorporating joint attention to improve maintenance of coordinated looks and with increased acknowledgment of novel objects (B) • Early intervention program started in hospital and continued with home visits to improve joint attention and initiating object requests (B) • Discrete trial training and pivotal response training when addressing joint attention to improve social limitations, spontaneous speech, and play skills (C) • Outcomes comparing the use of joint attention interventions vs. interventions using symbolic play and applied behavioral analysis were inconclusive (I)		
Interventions to Promote Motor Performance			
Developmental interventions for at-risk infants	• A caregiver-delivered home program for infants updated at 1, 2, and 3 months to improve motor performance (B) • Developmental motor interventions to improve motor outcomes (I)	• 5-week long parent education that models appropriate motor development (I)	
Interventions for children with or at risk for cerebral palsy (CP)	• Use of constraint-induced movement therapy to improve motor performance in young children with CP (A) • Use of neurodevelopmental treatment for young children with CP to improve motor performance (I) • Child-focused and context-focused intervention were equally likely to improve motor performance (B)	• Conductive education to improve motor performance in young children with CP (I)	
Visual–motor interventions for children with developmental delays	• Therapist-led sensorimotor therapy to improve gross motor and functional skills (C) • Child-led sensorimotor therapy to improve fine motor skills (C) • Occupational therapy for preschoolers to improve visual–motor and fine motor skills, manipulation, and motor accuracy (C) • Direct or indirect occupational therapy were equally likely to improve visual motor skills (C)		
Service Delivery in Early Childhood			
Studies regarding setting	• Providing interventions at more than one setting (e.g., classroom and home) to improve performance outcomes (B) • Participation in a Head Start Program at age 2 rather than age 3 to reduce maternal depression (B)		

Interventions	Recommended	No Recommendation	Not Recommended
	• Longer duration of home-based behavioral treatment to improve outcomes of children with autism or pervasive developmental disorder (C)		
Studies regarding routine-based intervention	• Family-centered help-giving that incorporates support to strengthen the family to improve satisfaction, parenting behavior, personal and family well-being, social support, and child behavior (B) • Use of routines-based or contextualized interventions to improve affect and engagement (C) • Use of everyday learning opportunities to improve parenting competence, parental well-being, and parent's judgment of child progress (C) • Interventions taking place during family routines to extinguish target behaviors and improve generalization of skills (C) • Family-centered service delivery to improve satisfaction and reduce family stress (C)		
Studies regarding parent training	• Parenting programs to improve parent-based outcomes (e.g., parent stress, anxiety, depression) (A) • Early Head Start parenting classes to improve cognitive outcomes in early childhood (B) • Addition of brief therapist-led parenting education to improve behavioral outcomes of young children (B) • Parent training to improve satisfaction and quality of life (C) • Community-based parenting group to reduce child difficulty and conduct problems (I)		

*Note: Criteria for level of evidence are based on the standard language from the Agency for Healthcare Research and Quality (2009). Suggested recommendations are based on the available evidence and content experts' clinical expertise regarding the value of using the intervention in practice.

Definitions:

Strength of Recommendations

A–There is strong evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. Good evidence was found that the intervention improves important outcomes and concludes that benefits substantially outweigh harm.

B–There is moderate evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. At least fair evidence was found that the intervention improves important outcomes and concludes that benefits outweigh harm.

C–There is weak evidence that the intervention can improve outcomes, and the balance of the benefits and harms may result either in a recommendation that occupational therapy practitioners routinely provide the intervention to eligible clients or in no recommendation as the balance of the benefits and harm is too close to justify a general recommendation.

D–Recommend that occupational therapy practitioners do not provide the intervention to eligible clients. At least fair evidence was found that the intervention is ineffective or that harm outweighs benefits.

I–Insufficient evidence to determine whether or not occupational therapy practitioners should be routinely providing the intervention. Evidence that the intervention is effective is lacking, of poor quality, or conflicting and the balance of benefits and harm cannot be determined.

Levels of Evidence for Occupational Therapy Outcomes Research

Evidence Level	Definitions
I	Systematic reviews, meta-analyses, randomized controlled trials
II	Two groups, nonrandomized studies (e.g., cohort, case control)
III	One group, nonrandomized (e.g., before and after, pretest and posttest)

Evidence Level	Definitions
IV	Descriptive studies that include analysis of outcomes (e.g., single-subject design, case series)
V	Case reports and expert opinion that include narrative literature reviews and consensus statements

Note: Adapted from "Evidence-based medicine: What it is and what it isn't." D. L. Sackett, W. M. Rosenberg, J. A. Muir Gray, R. B. Haynes, & W. S. Richardson, 1996, *British Medical Journal*, 312, pp. 71-72.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Developmental disabilities including:

- Social–emotional development disorders
- Feeding, eating, and swallowing disorders
- Cognitive development disorders
- Motor development disorders

Guideline Category

Counseling

Evaluation

Management

Prevention

Rehabilitation

Risk Assessment

Screening

Clinical Specialty

Family Practice

Gastroenterology

Neurology

Nutrition

Pediatrics

Physical Medicine and Rehabilitation

Preventive Medicine

Psychiatry

Psychology

Speech-Language Pathology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Dietitians

Health Care Providers

Health Plans

Managed Care Organizations

Nurses

Occupational Therapists

Patients

Physical Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Speech-Language Pathologists

Students

Utilization Management

Guideline Objective(s)

- To provide an overview of the occupational therapy process for children from birth through age 5 years
- To define the occupational therapy domain, process, and intervention that occur within the boundaries of acceptable practice
- To help occupational therapy practitioners, as well as individuals who manage, reimburse, or set policy regarding occupational therapy services, understand the contribution of occupational therapy in evaluating and serving children from birth through age 5
- To serve as a resource for parents, school administrators, educators, and other early childhood staff

Target Population

Children from birth through 5 years of age with a need for occupational therapy services

Interventions and Practices Considered

1. Social–emotional
    - Touch-based interventions
    - Relationship-based intervention
    - Interactional/play-based activities

    - Naturalistic interventions
    - Instruction-based intervention
    - Therapist-selected toys and objects
2. Feeding, eating, and swallowing
    - Behavioral-based intervention
    - Parent-directed educational-based interventions
    - Physiological interventions
3. Cognitive interventions
    - Neonatal intensive care unit (NICU): Newborn Individualized Developmental Care and Assessment Program
    - NICU and home-based interventions
    - Intervention to promote joint attention
4. Interventions to promote monitoring performance
    - Developmental interventions for at-risk infants
    - Interventions for children with or at risk for cerebral palsy (CP): constraint-induced movement therapy
    - Visual–motor interventions for children with developmental delays: therapist-led or child-led sensorimotor therapy

Major Outcomes Considered

- Effectiveness of occupational therapy interventions:
    - Promote social–emotional development
    - Improve feeding, eating, and swallowing
    - Improve motor performance
    - Improve cognitive development
- Quality-of-life
- Duration of home-based behavioral treatment
- Parenting programs

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The following 5 focused questions from the review of interventions for children 0 through 5 years were included in this Practice Guideline:

1. *Social–emotional development*: What is the effectiveness for interventions used in occupational therapy to promote social–emotional development for children 0 through 5?
2. *Feeding, eating, and swallowing*: What is the evidence for the effectiveness for interventions used in occupational therapy to improve feeding, eating, and swallowing for children 0 through 5?
3. *Motor development*: What is the evidence for the effectiveness of interventions within the scope of occupational therapy to improve motor performance for children 0 through 5?
4. *Cognitive development*: What is the evidence for the effectiveness of interventions within the scope of occupational therapy practice to improve cognitive development for children 0 through 5?
5. *Service delivery model*: What is the evidence for the effectiveness of different service delivery models used to improve occupational performance for children 0 through 5 and families receiving early intervention and early childhood services?

Search terms for the reviews were developed by the consultant to the American Occupational Therapy Association, Inc. (AOTA) Evidence-

Based Practice Project (EBP) and AOTA staff in consultation with the authors of each question and reviewed by the advisory group. The search terms were developed not only to capture pertinent articles but also to make sure that the terms relevant to the specific thesaurus of each database were included. Table C.2 in the original guideline document lists the search terms related to the population and interventions included in each systematic review. A medical research librarian with experience in completing systematic review searches conducted all searches and confirmed and improved the search strategies.

Databases and sites searched included Medline, PsycINFO, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Educational Resources Information Center (ERIC), and Occupational Therapy Systematic Evaluation of Evidence (OTseeker). In addition, consolidated information sources, such as the Cochrane Database of Systematic Reviews and the Campbell Collaboration, were included in the search. These databases are peer-reviewed summaries of journal articles and provide a system for clinicians and scientists to conduct evidence-based reviews of selected clinical questions and topics. Moreover, reference lists from articles included in the systematic reviews were examined for potential articles, and selected journals were hand-searched to ensure that all appropriate articles were included.

Inclusion and exclusion criteria are critical to the systematic review process because they provide the structure for the quality, type, and years of publication of the literature incorporated into a review. The review of all five questions was limited to peer-reviewed scientific literature published in English. The review also included consolidated information sources such as the Cochrane Collaboration. Reports listed on ERIC were included for the service delivery question.

The literature included in the review had been published between 1990 and 2010, and the study samples were children birth to age 5 and eligible for early intervention services. The intervention approaches examined were within the scope of practice of occupational therapy. The review excluded data from presentations, conference proceedings, non-peer-reviewed research literature, dissertations, and theses. Studies included in the review are Level I, II, and III evidence. Level IV evidence was included only where higher level evidence on a given topic was not found (see the "Rating Scheme for the Strength of the Evidence" field).

The consultant to the EBP Project completed the first step of eliminating references based on citation and abstract. Except in one situation in which the author worked on the review independently, the reviews were carried out as academic partnerships in which academic faculty worked with graduate students. Review teams completed the next step of eliminating references based on citations and abstracts. The full-text versions of potential articles were retrieved, and the review teams determined final inclusion in the review based on predetermined inclusion and exclusion criteria.

Number of Source Documents

A total of 112 articles were included in the final review.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence for Occupational Therapy Outcomes Research

Evidence Level	Definitions
I	Systematic reviews, meta-analyses, randomized controlled trials
II	Two groups, nonrandomized studies (e.g., cohort, case control)
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V	Case reports and expert opinion that include narrative literature reviews and consensus statements

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Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The teams working on each focused question reviewed the articles according to their quality (scientific rigor and lack of bias) and levels of evidence. Each article included in the review was then abstracted using an evidence table that provides a summary of the methods and findings of the article and an appraisal of the strengths and weaknesses of the study based on design and methodology. American Occupational Therapy Association, Inc. (AOTA) staff and an Evidence-Based Practice (EBP) Project consultant reviewed the evidence tables to ensure quality control.

The strength of the evidence is based on the guidelines of the U.S. Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm). The designation of "strong evidence" includes consistent results from well-conducted studies, usually at least two randomized controlled trials. A designation of "moderate evidence" may be based on one randomized controlled trial or two or more studies of lower levels of evidence. In addition, there may be some inconsistency of findings across individual studies that might preclude a classification of strong evidence. The designation of "limited evidence" may be based on few studies, flaws in the available studies, and some inconsistency in the findings across individual studies. A designation of "mixed" may indicate that the findings were inconsistent across studies in a given category. A designation of "insufficient evidence" may indicate that the number and quality of studies is too limited to make any clear classification.

Review authors also completed a Critically Appraised Topic, a summary and appraisal of the key findings, clinical bottom line, and implications for occupational therapy based on the articles included in the review for each question.

Strengths and Limitations of the Systematic Reviews

The 5 systematic reviews presented in this Practice Guideline have several strengths and include many aspects of occupational therapy practice for infants, toddlers, young children, and their families. The reviews included 112 articles, and three-fourths of the articles were Level I and II evidence, indicating that the evidence was of high quality. The reviews also involved systematic methodologies and incorporated quality control measures.

The limitations of the systematic reviews are based on the design and methods of individual studies and include small sample sizes and limited descriptions of the psychometric properties of a study's outcome measures. In addition, many of the studies in the review included concurrent interventions, and separating the effects of a single intervention may be difficult.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This study was initiated and supported by the American Occupational Therapy Association, Inc. (AOTA) as part of the Evidence-Based Practice (EBP) Project. In 2007, a Representative Assembly (RA) motion was passed "to charge the President to direct the Executive Director to direct resources to conduct an evidence-based literature review on the effectiveness of Occupational Therapy Services and Early Intervention." The RA charge reflected the need for occupational therapy practitioners to access findings from systematic reviews to support interventions within the scope of occupational therapy practice. In addition, the rationale for the RA charge was the increased incidence of childhood disorders and an interest in addressing barriers to early intervention occupational therapy services.

Four focused questions were initially developed for the systematic reviews of occupational therapy interventions for early intervention/early childhood and included questions related to social–emotional development; feeding, eating, and swallowing; preliteracy; and service delivery models. The questions were generated in conjunction with a group of content experts in early intervention/early childhood and EBP. Because of budget constraints, the project was put on hold until 2009. Following the review of the results of the search and development of summaries of the literature, the preliteracy question was divided into two questions, one examining intervention effects on motor outcomes and the other examining interventions that promote cognitive development related to preliteracy.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

A–There is strong evidence that occupational therapy practitioners should routinely provide the intervention to eligible clients. Good evidence was found that the intervention improves important outcomes and concludes that benefits substantially outweigh harm.

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C–There is weak evidence that the intervention can improve outcomes, and the balance of the benefits and harms may result either in a recommendation that occupational therapy practitioners routinely provide the intervention to eligible clients or in no recommendation as the balance of the benefits and harm is too close to justify a general recommendation.

D–Recommend that occupational therapy practitioners do not provide the intervention to eligible clients. At least fair evidence was found that the intervention is ineffective or that harm outweighs benefits.

I–Insufficient evidence to determine whether or not occupational therapy practitioners should be routinely providing the intervention. Evidence that the intervention is effective is lacking, of poor quality, or conflicting and the balance of benefits and harm cannot be determined.

Cost Analysis

The guideline developers reviewed published cost analyses.

Method of Guideline Validation

Peer Review

Description of Method of Guideline Validation

Not stated

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

The reviews included 112 articles, and three-fourths of the articles were Level I and II evidence, indicating that the evidence was of high quality. The reviews also involved systematic methodologies and incorporated quality control measures.

Number of Articles in Each Review at Each Level of Evidence						
	Evidence Level					
Review	**I**	**II**	**III**	**IV**	**V**	**Total in Each Review**
Social–emotional development	11	4	3	5	0	23
Feeding, eating, and swallowing	18	3	10	32	0	34
Service delivery models	8	4	3	3	0	18
Motor development	16	7	1	0	0	24
Cognitive development	12	0	0	1	0	13
Total	65	18	17	12	0	112

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

These guidelines may be used to assist:

- Occupational therapists and occupational therapy assistants in communicating about their services to external audiences
- Other health care practitioners, teachers, and program administrators in determining whether referral for occupational therapy services would be appropriate
- Third-party payers in understanding the medical necessity and the therapeutic need for occupational therapy services for children birth through 5
- Health and education planning teams in determining the developmental and educational need for occupational therapy services
- Legislators, third-party payers, and administrators in understanding the professional education, training, and skills of occupational therapists and occupational therapy assistants
- Program developers, administrators, legislators, and third-party payers in understanding the scope of occupational therapy services
- Program evaluators and policy analysts in determining outcome measures for analyzing the effectiveness of occupational therapy intervention
- Policy, education, and health care benefit analysts in understanding the appropriateness of occupational therapy services for children from birth through 5
- Occupational therapy educators in designing appropriate curricula that incorporate the role of occupational therapy with children from birth through 5

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

- This guideline does not discuss all possible methods of care, and although it does recommend some specific methods of care, the occupational therapist makes the ultimate judgment regarding the appropriateness of a given intervention in light of a specific person's circumstances, needs, and available evidence to support the intervention.
- This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold or distributed with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.
- It is the objective of the American Occupational Therapy Association, Inc. (AOTA) to be a forum for free expression and interchange of ideas. The opinions expressed by the contributors to this work are their own and not necessarily those of the AOTA.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Patient Resources

Resources

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

Clark GF, Kingsley K. Occupational therapy practice guidelines for early childhood: birth through 5 years. Bethesda (MD): American Occupational Therapy Association, Inc. (AOTA); 2013. 154 p. [304 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2013

Guideline Developer(s)

American Occupational Therapy Association, Inc. - Professional Association

Source(s) of Funding

American Occupational Therapy Association, Inc.

Guideline Committee

Not stated

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Financial Disclosures/Conflicts of Interest

The authors of this Practice Guideline have signed a Conflict of Interest statement indicating that they have no conflicts that would bear on this work.

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Electronic copies: Not available at this time.

Print copies: Available for purchase from The American Occupational Therapy Association (AOTA), Inc., 4720 Montgomery Lane, Bethesda, MD 20814, Phone: 1-877-404-AOTA (2682), TDD: 800-377-8555, Fax: 301-652-7711. This guideline can also be ordered online at the AOTA Web site.

Availability of Companion Documents

The following is available:

- Occupational therapy practice framework: domain and process. 2nd ed. 2008. Available to order from the American Occupational Therapy Association (AOTA) Web site.
- Occupational therapy for young children birth through 5 years of age. Fact sheet. Bethesda (MD): American Occupational Therapy Association, Inc. (AOTA); 2011. 2 p. Electronic copies: Available in Portable Document Format (PDF) from the AOTA Web site.

In addition, case studies are available in the original guideline document.

Patient Resources

Tip sheets on various topics for children and youth are available from the American Occupational Therapy Association (AOTA) Web site.

NGC Status

This NGC summary was completed by ECRI Institute on February 3, 2014.

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